WISCONSIN'S AGING AND DISABILITY RESOURCE CENTER (ADRC)

FIVE YEAR PLAN

2011-2016

Wisconsin Department of Health Services
Bureau of Aging and Disability Resources
Office for Resource Center Development
July 1, 2011

WISCONSIN'S AGING AND DISABILITY RESOURCE CENTER

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Aging and Disability Resource Center Mission Statement

To empower and support seniors, people with disabilities and their families to ask for help, find a way to live with dignity and security, and achieve maximum independence and quality of life.

SECTION I: INTRODUCTION

A. Framework for Wisconsin's 2011-2016 Five Year ADRC Plan

After years of collaborative planning, it was in 1998 that the State of Wisconsin, Department of Health and Family Services, submitted its proposal for redesigning Wisconsin's long-term care system. The plan outlined a vision for a system that begins with Aging and Disability Resource Centers and incorporates the guiding principles of choice, access, quality, and cost-effectiveness. The 1998 proposal set the stage for the ADRC vision and recognized that the key to the success of the long-term care redesign is in strong Aging and Disability Resource Centers.

As required by the Administration on Aging for the Five-Year ADRC Plan, it is in this proposal that the foundation is laid for:

1. The ways to improve services for older adults and people with disabilities;
2. How the State is going to realign and more optimally coordinate its existing information and access function in order to operationalize ADRCs statewide.
3. How the ADRC fits into Wisconsin's broader long-term care systems change efforts.

Since 1998, ideas have been refined and details have been added. The State's economy has changed, budgets have changed, and expansion has been slower than initially envisioned. New governors, legislators, and administrators have been elected or selected. However, the core values, vision, and support for Aging and Disability Resource Centers remains.

Therefore, the plans laid out in this five year ADRC plan, are those that will strengthen ADRCs in the State of Wisconsin so that they can remain strong and vital to the long-term care system.

B. Vision Statement

Wisconsin's ADRC vision is consistent with AoA's ADRC vision to have ADRCs in every community; serving as highly visible and trusted places where adults with disabilities of all ages can find information on the full range of long-term care options and can access a single point of entry to long-term support programs and benefits.

C. Contact Information

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D. Participants in ADRC Statewide Plan Development

This five year plan covers the final phase of statewide ADRC implementation in Wisconsin, following 15 years of planning, pilot testing and roll out. As of July 2011, Wisconsin has 35 ADRCs serving 59 of the State's 72 counties. Statewide coverage is anticipated in 2012. A large number of partners, including hundreds of consumers, aging and disability advocates and organizations, state and county agency representatives, and elected officials, have been involved throughout the process.

The following are key players and responsible parties in the current five year ADRC plan cycle:

Overall responsibility and leadership is provided by Donna McDowell, Director of the Bureau of Aging and Disability Resources (BADR) in the Wisconsin Department of Health Services (DHS). DHS is Wisconsin's State Unit on Aging, Disabilities Agency and State Medicaid Agency. The Office for Resource Center Development (ORCD), directed by Janice Smith, is responsible for ADRC expansion, including issuing the RFP, selecting new sites, and administering the ADRC program. Carrie Molke in ORCD is the lead staff responsible for plan preparation and oversight of the State's ADRC quality assurance program.

The Wisconsin Council on Long Term Care provides advice and direction to the DHS on system design and implementation of Wisconsin's ADRCs and its Medicaid managed long term care and self directed supports waivers. The Council is chaired by Heather Bruemmer, Director of the Wisconsin Board on Aging and Long Term Care, the State's long term care ombudsman. Other members include representatives of an Area Agency on Aging, Independent Living Center, an ADRC, a Medicaid managed long term care organization, the state protection and advocacy agency for people with disabilities, the Board for People with Developmental Disabilities, AARP, the Wisconsin County Human Services Association, and nursing home and assisted living trade associations, among others.

Stakeholders are also involved at the local level, in both the planning and implementation of local ADRCs and providing direction to DHS. DHS requires the active involvement of the following stakeholders in development of the initial application for each local ADRC: county aging programs, long term care waiver programs, programs for people with mental illness and substance use disorders; social service programs, and economic support units. Ongoing oversight for local ADRCs is provided by a governing board, one quarter of whose membership is required by statute to include older persons and persons with physical or developmental disabilities or their family members, guardians or other advocates. State DHS staff meet six times a year with local ADRC directors to coordinate and get feedback and direction.

SECTION II: 2011-2016 GOALS

A. Goal Statements: 2011-2016 Goals for Wisconsin ADRCs

1. Expand Aging and Disability Resource Centers (ADRCs) to all Wisconsin counties and tribes by the end of 2012.
2. Increase public awareness and use of ADRC services.
3. Prevent or delay entrance into publicly funded long-term care programs.
4. Implement healthcare transition interventions that prevent and/ or avoid readmissions to the hospital within 30 days after discharge.
5. Develop and implement a comprehensive quality improvement program for Aging and Disability Resource Centers.

B. Goal Description, Timeframe, Measures of Success

The charts found on the following pages show the activities related to each goal. The description, timeframes and measures of success for each of the above five goal statements are described.

C. Projected Cost Savings of Implementing Goals

The overall cost impact of implementing the Goals set forth in this five-year plan will be developed and measured in accordance with each individual project. Within each project description, the impact (including the cost impact) of the initiative will be measured.

It is anticipated that there will be significant savings in both customer's personal funds and in public and private programs.

Goal #1: Expand Aging and Disability Resource Centers (ADRCs) to all Wisconsin counties and tribes by 2012.

Goal 1A. Expand ADRC coverage from 85% of the State's population to 100% by the end of 2012.
Goal 1B. Expand ADRC services to all 11 Wisconsin tribes by the end of 2012.

Activity	Description	Timeframe	Measures of Success
Secure funding for ADRC expansion	Inclusion of funding for ADRC expansion in the 2011-13 State budget is needed in order for expansion to occur. Funding is included in the budget and is expected to be signed by the Governor.	July 1, 2011	2011-13 budget passage with funding for ADRC expansion included.
Receive ADRC applications	ADRC applicants send application to the Office for Resource Center Development (ORCD) for review and approval. Applications due four months prior to scheduled start date.	September 1, 2011 – July, 2012	Applications received for: 1. Rock 2. Green Lake/ Marquette/ Waushara/ Adams 3. Door 4. Marinette/ Florence 5. Northwoods 6. Wolf River 7. Dane 8. Oneida Tribe 9. Ho Chunk Tribe
Follow application review and start-up process	1. Internal ORCD Review; 2. Conference call with applicant to provide feedback on application; 3. Trainings scheduled and provided; 4. Policy and procedure development, review and approval; 5. Monthly conference calls scheduled and provided; 6. Approve final version of the application.	September 1, 2011 – July, 2012	1. Nine applications are reviewed. 2. Conference calls are completed. 3. Trainings are provided. 4. Policy and procedures are approved. 5. Monthly conference calls are completed. 6. Final application is approved for all nine applicants.
ADRC Start of Operations	1. Letter of intent to contract is issued upon approved final application; 2. One month prior to ADRC start, contract issued from DHS to the ADRC; 3. ADRC opens.	45 days prior to ADRC start date. One month prior to ADRC start date	1. All nine new ADRCs and Tribal ADRS' are operational by the end of 2012. 2. 100% of WI's population has access to Aging and Disability Resource Centers by the end of 2012.

Goal #2: Increase public awareness and use of ADRC services.

Goal 2A. Increase overall ADRC contacts by 5% each year.
2A Sub-Goal 1. Increase ADRC customers that are currently underutilizing the ADRC by 5% each year.
2A Sub-Goal 2. Increase private pay customers by 5% each year.
Goal 2B. Increase institutional relocations by 10% over 5 years.

Activity	Description	Timeframe	Measures of Success
Launch statewide marketing initiative	1. Secure grant funding for statewide marketing initiative.	July 1, 2011	1. Funding is secured.
	2. Analyze and determine the sub-groups of ADRC customers that are currently underutilizing the ADRC.	January 1, 2012	2a. Analysis complete. 2b. Subgroups identified. 2c. Targets are established for subgroups (numbers of customers aiming for).
	3. Contract with marketing expert to develop quality marketing materials and a strategy/ plan.	January 1, 2012	3. A contract is in place.
	4. Develop materials and plan for a statewide marketing initiative.	January 1, 2012- January 1, 2013	4. Materials are developed and meet standards for quality. Implementation plan developed.
	5. Execute plan after statewide ADRC availability.	January 1, 2013 – January 1, 2014	5. Marketing activities developed in plan are complete.
	6. Evaluate success of initiative and adopt, abandon, or adapt plan for following year.	January 1, 2014	6a. ADRC customers increase. 6b. Institutional relocations increase. 6c. Private pay customers increase. 6d. If no increase is evident, revise marketing plan as necessary for 2014-15 and each year thereafter.
	7. Plan for additional statewide marketing initiatives yearly thereafter.	January 1, 2014 – January 1, 2016	7. Plan is in place for 2014-15. (Plan, execute, evaluate, revise/ adopt for each year thereafter.)

Activity	Description	Timeframe	Measures of Success
Provide technical assistance and training to ADRCs for local marketing efforts	1. Develop model outreach and marketing plan for local ADRC marketing initiatives.	January 2014-January 2015	1. Model plan developed and distributed.
	2. Develop/ improve marketing toolkit for ADRC use.	January 2014 – January 2015	2. Marketing toolkit complete and distributed.
	3. Develop and provide training and technical assistance (TA).	January 2015 – January 2016.	3a. Training is provided. 3b. Technical assistance is provided.
Outreach to residents in nursing homes (NH), Intermediate Care Facilities – Mental Retardation (ICFs-MR), and assisted living facilities, such as Community Based Residential Facilities (CBRF), and Residential Care Apartment Complexes (RCAC).	1. Develop plan and any technical assistance required for ADRCs to conduct outreach activities to residents in NHs, ICFs-MR, CBRFs, and RCACs.	January 2012-January 2013	1a. Plan developed. 1b. Necessary TA developed and distributed.
	2. Implement plan for outreach to residents in NHs, ICFs-MR, CBRFs, RCACs explaining ADRC services and contact information.	January 2013-2014 and ongoing	2. Activities outlined in the plan are implemented by all ADRCs.
	3. If adults in facilities contact or are referred to the ADRC, a range of services are provided: Information and Assistance (I&A), options counseling with decision support, Medicaid Home and community based services waivers (HCBS) eligibility determination, enrollment as possible, relocations for people who request assistance in relocating to community living.	Ongoing	3. Individualized services are provided to individuals who contact or are referred to the ADRC through the outreach process.
	4. Track activities and evaluate impact of outreach efforts. Adopt, abandon, or adapt plan for following year.	Ongoing tracking. Evaluation January, 2014.	4a. Numbers of contacts (adults in NHs, ICFs-MR, CBRF's and RCAC's specifically) are tracked. 4b. Type of activity provided is tracked. 4c. Outcome of interaction with the ADRC is available and evaluated. Evaluation

			complete. Data re: numbers of relocations is available. 4d. Plan modified as necessary for following year.
MDS-Q referrals from nursing homes	1. Monitor monthly referrals to ensure that all nursing homes are making required and appropriate referrals and inform the nursing home licensing agency (Division of Quality Assurance (DQA)) when NHs are making no referrals.	January 2011 - Ongoing	1a. Monitoring process is operational. 1b. Number of NHs not referring under Section Q are identified and referred to DQA. 1c. DQA provides follow-up for NHs. 1d. Decreases in non-referral NHs.
	2. Provide updates to ADRCs on processes (as released by CMS).	Ongoing	2. Internal DHS workgroup provides TA to ADRCs/ Local Contact Agencies (LCAs) as necessary
	3. Develop and automate Section Q referral process.	June 2012	3. Electronic process is operational for all nursing homes and local contact agencies
	4. Track numbers of relocations and evaluate impact of initiative. Make any improvements as necessary.	On-going	4. Data re: number of relocations is available and measured against Goal.
Evaluate effectiveness of activities in achieving goal	1. Evaluate the degree to which overall goals have been achieved through the four initiatives described above.	Annually	1. An evaluation is conducted.
	2. Make revisions to approach as necessary.	On-going	2. Revisions are made if necessary.
	3. Plan for on-going efforts to support/ achieve goal to continually increase public awareness and use of ADRC services.	On-going	3. Plan developed and implemented.

Goal #3: Prevent and delay entrance into publicly funded long-term care programs.

Goal 3A. Prevent and delay entrance into institutional settings for all client groups served through options counseling.
Goal 3B. Increase the number of contacts/ conversations with private-pay customers in planning future long-term care needs.
Goal 3C. Increase number of I&A and options counseling contacts where home and community based care options are discussed.
Goal 3D. Increase prevention tools, referrals, activities and programs that will improve customer's ability to remain healthy at home.
Goal 3E. Implement evidence based methods aimed at enhancing the quality of life of persons living with Alzheimer's disease and their caregivers.

Activity	Description	Timeframe	Measures of Success
Implement standard operating procedures for options counseling (funded under AoA grant) Note: The options counseling standards include a discovery tool to use with customers to identify full-range of needs for assistance, and an action plan to support customers in preparing for future long-term care needs.	1. Organize and implement an advisory committee to solicit ideas regarding options counseling standards and receive feedback. Interview staff at three ADRC pilot sites to elicit their thoughts about options counseling.	October, 2010 and on-going	1a. Advisory committee organized and meetings occur. 1b. Staff interviews complete and analyzed.
	2. Conduct a customer survey (prior to implementation of OC standards) to provide baseline/ pre-test information.	August, 2011	2. Customer survey complete.
	3. Develop draft standards and train pilot sites on the tools and techniques for providing options counseling.	June-August, 2012	3a. Final draft of standards complete. Tools complete. 3b. Pilot sites trained on standards/ tools.
	4. Pilot options counseling standards with customers.	August, 2011-December, 2012	4. Pilot test complete.
	5. Conduct a customer survey/ evaluation to study impact of standards. Revise tools and provide additional training as necessary.	Late 2012	5a. Evaluation complete and analyzed. 5b. Revisions complete (if required).
	6. Deploy/ implement standards statewide.	2013-2014	6. 100% of ADRCs implement the standards, tools and techniques when providing options counseling to customers.
	7. Develop seven options counseling training modules available in a new self-paced computer based training format.	2011-2012	7a. Seven training modules complete. 7b. Modules released for use by 100% of ADRCs.

Prevent and delay entrance into public programs…continued on next page

Community Living Program (CLP grant) (funded under AoA grant)	1. Request a no cost extension for CLP grant.	July, 2011	1. No cost extension approved for FY 2012.
	2. Complete all grant activities, including the provision of short-term service coordination and other activities to prevent premature nursing home admission.	September, 2012	2. Final grant report and evaluation completed.
	3. Incorporate lessons learned into ongoing ADRC operations and future initiatives, such as health care transitions.	December, 2012 and Ongoing	3. Lessons incorporated.
Veteran Directed Home and Community Based Services Grant (funded under AoA grant)	1. Request no cost extension in conjunction with CLP grant in order to continue to support the program while VA funding is available through 2012.	July, 2011	1. Support for VDHCBS is continued for the duration of VA demonstration funding.
	2. Complete evaluation report to document financial savings and improved quality of life for veterans self-directing their care at home. Program continues.	December, 2012	2a. Evaluation report completed. 2b. Milwaukee VA Medical Center continues program without VDHCBS grant support.
Evidence-Based Prevention Programs	1. Support Office on Aging in efforts to decrease number of Living Well with Chronic Conditions (CDSMP) program cancellations and improve local program coordination in ADRC service area.	Ongoing	1. Increase in percent of newly trained leaders who complete Living Well program within four months of training.
	2. Increase the number of participants completing evidence based fall prevention programs (Stepping On-Falls Prevention).	Ongoing	2a. Increase the number of Stepping On programs available in ADRC regions. 2b. Increase annually in participants completing fall prevention programs. 2c. Decrease in number of falls and hospital costs for participants in Stepping On program.
	3. Expand fall prevention coalitions in ADRC regions.	May 2011-2016	3. Increase in the number of ADRCs involved in falls prevention coalitions by 10% each year over five years.
	4. Educate ADRC Directors about Evidence-based Care Transition models (EBCTP) and support ADRCs in providing EBCTP.	June 2011-2014	4a. Three ADRCs will provide EBCTP in three years. 4b. Two additional ADRCs have EBCTP in five years.
Active Aging Project: Bringing Communities and Technology Together for Healthy Aging (AHRQ grant)	1. Co-chair project steering committee and assist with grant activities.	June 2011-ongoing	1a. Project steering committee established. 1b. Office on Aging and Office for Resource Center Development actively involved in technology development and community based participatory research.

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	2. Three ADRC sites participate in pilot-testing of Asset Based Community Development (ABCD) and newly developed technology.	August, 2011-2015	2a. Study Coordinator hired for each ADRC. 2b. ABCE process completed. 2c. Pilot testing of technology completed.
	3. After completion of ABCD process, ADRCs collaborate with technology researcher to develop and test four "technologies": (1) Comprehensive Health Enhancement Support System (E-CHESS) developed specifically for elders and family caregivers to promote active aging and independence; (2) driver safety; (3) radio frequency identification product to determine reliability and timeliness of in-home services; and (4) Stepping On falls prevention program development for individuals via E-CHESS.	2012-2016	3a. Rapid cycle testing of new technologies. 3b. Technologies tested by research subjects. 3c. Data collection and analysis completed.
	4. Office for Resource Center Development (ORCD) and ADRCs assists in incorporating Care Transitions and Stepping On into E-CHESS program.	June 2011-2014	4. E-CHESS will contain Modules for Care Transitions and Stepping On (falls prevention)
	5. Evaluate the ABCD methodology and the four technologies.	2014	5. Evaluation complete and analyzed.
	6. Dissemination and expansion to other ADRCs.	2014-2015	6a. Results are shared with interested parties, including ADRCs in WI. 6b. Expansion plan in place and implemented re: statewide expansion of tools/ process/ technologies.
Alzheimer's Disease Initiatives: Memory Screens & Improved Coordination with Physicians and other Alzheimer's Supportive Service Organizations (funded under AoA grant)	1. ADRC of Portage County implements ADSSP project. Dementia Outreach Specialist hired.	January, 2010	1a. Innovation project begins. 1b. Staff hired.
	2. Dementia Outreach Specialists are trained to perform memory screens and referral system developed between ADRC and physicians.	2010	2a. Implement memory screens in clinic, at ADRC, community events, in-home. 2b. Wrap around services/ referrals are evident in the community.
	3. Develop memory screen and referral processes training program to disseminate innovative findings to other ADRCS and interested agencies.	Sept, 2010 and Ongoing	3a. Collaborate with Alzheimer Chapters and related organizations to develop Dementia 101 components for training program. 3b. Present two training programs and on webcast with project partners. 3c. Incorporate into State Plan on Dementia.

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	4. Offer memory screening as an ADRC activity statewide. Goal to increase the number of ADRCs that offer memory screen by 30%.	August, 2011-2015	4a. Identify baseline number of ADRCs performing memory screens. 4b. Increase of 20% in two years. 4c. Increase of 30% in five years.
	5. Improve coordination in referrals to and from local Alzheimer's supportive services organizations.	June, 2011 and Ongoing	5a. Efficiency and ease of referrals measured. 5b. Coordination improved or process is refined.
	6. Develop ADRC data reporting system and document baseline # of referrals to and from Alzheimer's Assoc., dementia diagnostic clinics, etc.; collect information annually with increase of 10% evident each year.	TBD	6a. Data reporting system is in place. 6b. Baseline referral data collected and available. 6c. 10% increase in referrals annually.
	7. Implement the recommendations from the State Plan for Alzheimer's Disease (from State Aging Plan).	Dec. 2012 and as available	7. Written State Plan disseminated to ADRCs with updates as available.
Alzheimer's Disease Initiatives: Memory Care Connections (funded under AoA grant)	1. Begin pilot program in Northwestern WI ADRCs.	October, 2010	1. Training is completed, marketing materials distributed, ongoing enrollment occurs
	2. Program staff hired and trained.	March, 2011	2. Program staff hired and trained.
	3. Develop marketing and outreach strategies, develop materials, and implement strategy. Calls made to ADRC or Alzheimer's. Association. Target of 100 participants/ enrollments.	January 2011	3. Marketing and outreach strategies identified, materials developed, and strategy implemented. Target enrollments achieved.
	4. Six individualized counseling sessions to spousal caregivers of people with AD and their families are provided. Two individual sessions, and four family sessions. Continuous telephone support to caregivers available.	April, 2011-Ongoing	4a. Six counseling sessions provided. 4b. Telephone support available and being utilized.
	5. Post counseling, provide access to caregiver support groups for project participants through coordination with ADRC and Alzheimer's Association chapters.	Ongoing	5. Caregiver support groups are available and access provided.

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	6. Program impact measured/ evaluated. Outcomes anticipated include: improved mental and physical health, improved coping skills, satisfaction with familial support for spousal caregivers, and delayed admission of people with AD to nursing homes.	April, 2011-Ongoing	6. Evaluation complete and analyzed.
	7. Implement program statewide if found to be effective in achieving Goals.	2012-13	7. Implement in 30% of ADRCs within the first year.
Alzheimer's Disease Initiatives: Language Enhanced Exercise Plus Socialization (LEEPS) program (funded under AoA grant)	1. Begin pilot program in SW-North, SW-South ADRCs.	October, 2010	1. Pilot project underway in the ADRCs of SW-N and SW-S.
	2. Hire program coordinator.	January 1, 2011	2. Program coordinator hired.
	3. Recruit and hire Volunteer Coordinators.	April, 2011	3. Volunteer Coordinators hired.
	4. 100 Participants recruited, begin enrollments.	May, 2011	4. 100 enrollments achieved.
	5. Individual exercise programs, fit into person's abilities and preferences, developed and implemented.	May, 2011-Ongoing	5. Exercise program implemented for 100 participants.
	6. Implement program for linguistic stimulation, volunteer work in the community and social outings for enjoyment.	May, 2011-Ongoing	6. Program implemented for 100 participants.
	7. Program evaluation. Measurements include: (1) decrease in caregiver burden; (2) increase in satisfaction with role as a caregiver; and (3) improved physical fitness and mood of the individual with dementia.	Ongoing	7. Evaluation completed and analyzed.
	8. Statewide implementation of LEEPs program.	2013 or TBD	8. LEEPs program implemented in 30% of ADRCs in the first year.
Alzheimer's Disease Initiatives: Veteran Caregiver Connections program (funded under AoA grant)	1. Begin implementation of program designed to improve the knowledge, referral and information-sharing networks between the VAMC in SE WI and Alzheimer's Association SE Chapter.	January, 2011	1. Implementation begins.
	2. Conduct a pre-test with ADRC staff to understand current levels of knowledge and assess pre-conceptions. Post-test after training provided.	March, 2011	2. Tests completed and analyzed.
	3. Provide training to ADRC staff from the Alzheimer's Association and the VA on the disease and services these entities provide.	March, 2011	3. Training provided to ADRC staff from the ADRCs of Waukesha, Milwaukee, Racine and Kenosha.
	4. VA staff training in regard to the services of the	March, 2011	4. Training provided to VA staff in

Prevent and delay entrance into public programs…continued on next page

	ADRC and Alzheimer's Association.		Milwaukee area.
	5. Create DVD to target veterans and explain what an ADRC is and can do for them.	May-June, 2011	5. DVD complete and distributed to all parties.
	6. Program evaluation and statewide implementation if meets program goals.	July 1- TBD	6a. Program evaluation complete. 6b. Statewide implementation complete, if applicable.
Pre-admission consultation (PAC)	1. Implement change in policy for pre-admission consultation for nursing home and assisted living facilities.	June 2011 and Ongoing	1a. Policy disseminated by June, 2011. 1b. New brochures published by June, 2011.
	2. ADRCs provide consultation to people who learn about the resource center through the PAC informational brochure.	June, 2011 and Ongoing	2. Customers contact the ADRC after receiving the PAC brochure at the facility. ADRCs provide consultation prior to admission to the facility.
	3. Develop a system for and track # s of conversations with people considering nursing home or assisted living.	July 1, 2011-2012 Ongoing	3a. System developed, in-place, and used. 3b. numbers of conversations are available.
	4. Develop and track measures to assess impact and effectiveness of pre-admission consultation.	July 1, 2011-Ongoing	4a. Measures to assess impact and effectiveness of PAC developed. 4b. Data available and analyzed.
Motivational Interviewing (MI) (Partially funded under AoA grant)	1. Develop and implement curriculum and tools to build skill level using motivational interviewing strategies.	August 2011-December 2011	1. Curriculum and tools developed and available.
	2. Contract with MINT trainer to provide regional trainings to ADRC staff throughout the state.	May-September 2011	2a. Contractor in place. 2b. Four regional trainings provided. 2c. 50% of ADRCs attend at least one regional training.
	3. Two ADRCs participate in a research project to study how the spirit of MI impacts ADRC workplace and service to ADRC customers. (Partnership with the University of Wisconsin and a MINT Trainer from Viterbo College.) Receive and distribute results.	TBD	3a. Research project complete. 3b. Results distributed and analyzed.
	4. Develop and implement MI coaching strategies at ADRCs. Provide training to coaches. MI coaching manual developed and disseminated at regional training.	2011 and Ongoing	4a. Coaching manual complete and available. 4b. Training provided to coaches.
	5. Develop and implement on-line training to support on-going ADRC staff development, including use for	June-December, 2011	5. On-line training available.

	new hires and a refresher course for experienced counselors.		
	6. Evaluate effectiveness of MI training and impact on customers (in conjunction with the options counseling standards grant evaluation).	2011-2012	6. Evaluation and analysis complete.

Goal #4: Implement Health Care Transition interventions that prevent and/or avoid hospital readmissions within 30 days after discharge.

Activity	Description	Timeframe	Measures of Success
Define Wisconsin approach to health care transitions, including role of ADRC	1. Learn about national care transition movement and rationale for change in service coordination and delivery at time of hospital discharge.	Ongoing	1. Increase the number of ADRCs that formalize partnerships with hospitals for enhance care transitions as determined by select survey.
	2. Develop relationship with partners exploring care transition strategies.	March, 2011-2016	2. Annually increase the number of partners that collaborate with State policy makers.
Develop plan for implementing a WI ADRC approach to health care transitions	1. Convene internal ORCD Care Transition Workgroup.	April, 2011 ongoing	1. Increase in number ADRCs implementing care transition activities as determined by responses to select survey (baseline 2011, percent change 2013 and 2015).
	2. Convene external Care Transition Workgroup.	July, 2011	2. External ADRC CT workgroup meetings occur.
	3. Propose WI ADRC Care Transitions Model that allows ADRCs flexibility in meeting community needs.	September. 2011	3. Written CT proposal is presented to Directors and Department.
	4. Request feedback from ADRCs regarding: proposed health care transition model.	September, 2011	4. Written and verbal comments to proposed plan received and considered.
Execute implementation plan	1. Inform ADRC Directors of national CMS and AoA Care Transition strategies.	April, 2011-Dec., 2012	1. Presentations/discussions with ADRC Directors complete.
	2. Support ADRCs in efforts to develop local coalitions and/or secure project funding for care transitions projects.	Ongoing	2. Provide assistance and letters of support for local agencies applying for CT grants.
	3. Provide education and resources about range of care transition activities, including evidence based models that ADRCs can implement.	Ongoing	3. Education, technical assistance and resources that encourage ADRC care transition activities are complete.
	4. Implement plan. ADRCs implement EBCT programs.	On-going	4a. Activities in plan implemented. 4b. Number of ADRCs implementing EBCTP increases from zero to 10 in five years.

Health care transitions…continued on next page

Measure impact of health care transition activities for customers	1. Develop and deploy a select survey to identify baseline ADRC care transition activities; repeat the survey in two and four years.	Sept. 2011 Sept. 2013 Sept. 2015	1a. Number of ADRC that increase care transition activities offered each year surveyed. 1b. Number of reported care transition activities increases by 40% in five years.
	2. Develop and implement changes in ADRC data reporting to reflect consumers receiving a range of health care transition services	2011-2014	2. Components of care transition service are listed and reported in annual ADRC activity reporting.
	4. Bureau applies for care transition funding if available and consistent with ADRC model.	Ongoing	4. Review grant opportunities and submit application if eligible to apply.

Goal #5: Develop and implement a comprehensive quality improvement program for Aging and Disability Resource Centers.

Goal 5A. Improve or maintain high levels of customer satisfaction with ADRC services each year.
Goal 5B. Increase the timely and efficient access to programs and services.
Goal 5C. Increase the quality, consistency, and viability of databases and other systems used to support: activity reporting, community resource information, web-based customer searching, ADRC operations and quality improvement.

Activity	Description	Timeframe	Measures of Success
Develop evidence-based, customer focused measures of quality ADRC services (developed under AoA ADRC grant)	1. Information and Assistance and Options Counseling Research and Evaluation Project.	End March, 2011	1a. Research project complete. 1b. Statewide and individual ADRC reports received. 1c. Statewide and individual opportunities for improvement are identified.
	2. Enrollment Counseling and Enrollment Systems Research Project.	End December, 2011	2a. Research project complete. 2b. Statewide and individual ADRC reports received. 2c. Statewide and individual opportunities for improvement are identified.
Plan for and execute annual evaluation of ADRC services	1. Develop a comprehensive plan for conducting evaluations of ADRC services. Plan includes ADRC self-evaluation, customer evaluation, and state-level evaluation. Plan defines roles and responsibilities of each entity and timeframes.	July 2011- July 2012.	1. Plan complete.
	2. Execute evaluation plan.	Annually	2. Activities in plan are implemented.
	3. Evaluate plan, modify as necessary.	Annually	3. Plan is evaluated. If modifications are necessary, they are made.

Quality…continued on the next page.

Implement statewide process improvement strategy (partially funded under AoA grant)	1. Hire consultant to assist in development of a WI ADRC approach to Quality Improvement (QI).	2010	1a. RFP developed and open for bid. 1b. Applications reviewed and scored. Vendor selected. 1c. Consultant hired.
	2. Provide regional training to Aging and Disability Resource Centers on QI. Aim for 85% ADRC participation.	September 2010-September 2011	2a. 5 Regional trainings provided. 2b. 85% ADRC participation.
	3. ADRCs implement local projects, measure results.	Annually	3. 35 ADRCs implement individual quality improvement project.
	4. Provide on-site technical support to local ADRCs as they implement the QI framework locally.	Annually	4. On-site visits are complete.
	5. Conduct an evaluation of the QI initiative to determine whether approach is effective and sustainable.	By Sept. 2012	5. Evaluation complete. Report received.
	6. Make modifications as necessary to QI framework.	Sept. 2012 and on-going	6. Modifications are made.
	7. Develop and execute sustainability plan.	July 2011-ongoing	7. Sustainability plan is developed.
	8. Annually report results of QI initiatives.	Annually	8. Annual reports are completed each year.
Implement a strategy to increase the quality of databases used for ADRC services	1. Develop key requirements for an effective IT system that will improve the administration of services, customer use-ability, and overall quality of service delivery.	January, 2011	1. Requirements developed.
	2. Secure necessary funding.	January, 2011	2. Funding secured.
	3. Identify vendors that will best meet key requirements.	April-October, 2011	3a. RFP developed and released. 3b. Vendor proposals received. 3c. Bids/ applications reviewed. 3d. Vendor(s) selected.
	4. Implement new systems.	TBD	4. 50% or more of ADRCs utilize selected vendor for their IT systems.
	5. Develop technical assistance and training plan to (1) use the new systems effectively, (2) ensure adequacy of resource information, (3) ensure consistent use of resource information, (4) continually improve the integrity of encounter reporting data.	TBD	5a. Technical assistance and training plan developed. Training plan implemented.

SECTION III: FINANCIAL PLAN - RESOURCES TO SUSTAIN EFFORTS

A. Existing funds/ programs currently used to carry out ADRC activities.

ADRCs are budgeted to receive $30.2 million in state general purpose revenue and $11.6 million in federal Medicaid administrative match funds in 2011.

Funding is allocated to individual ADRCs based on a formula that reflects the size of the population they serve and the cost to operate a hypothetical ADRC serving 1% of the State's adult population (estimated at $487,301 in 2008). ADRCs serving sparsely populated areas receive a minimum annual allocation and can qualify for a financial incentive by joining to form a larger, more robust regional ADRC.

State and federal funding is available to support Tribal Aging and Disability Resource Specialists, who provide information and assistance and options counseling and help tribal members access other ADRC services. State and federal funding also support Tribal Disability Benefit Specialists at the Great Lakes Inter-Tribal Council (GLITC).

FIGURE 1: ADRC REVENUES BY SOURCE (2011)

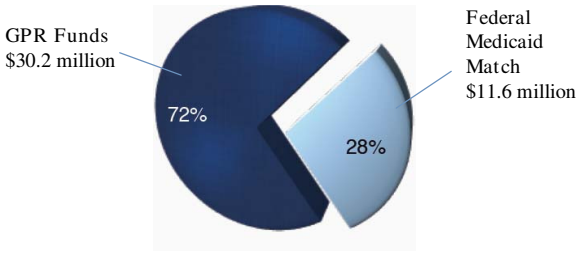
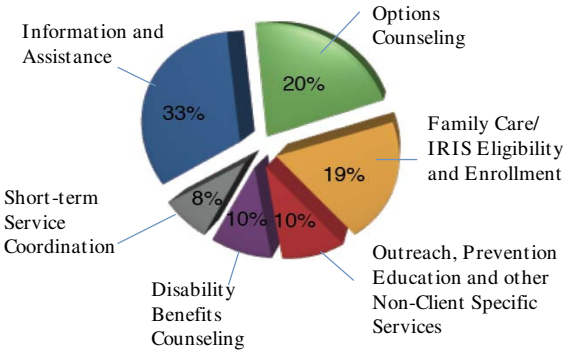


FIGURE 2: ADRC EXPENDITURES, BY CATEGORY OF SERVICE PROVIDED (2011)



Funding Per ADRC

ADRC Funding for Calendar Year 2011

TABLE 1: ADRC FUNDING FOR CALENDAR YEAR 2011

ADRC/County	% of WI Adult Population	State GPR	Federal MA Match	All Funds
Barron (fiscal agent)	0.86%	592,468	117,065	709,533
Rusk	0.29%			
Washburn	0.32%			
ADRC of the North		693,722	269,781	963,503
Bayfield (fiscal agent)	0.29%			
Ashland	0.31%			
Iron	0.14%			
Price	0.30%			
Sawyer	0.32%			
Brown	4.26%	1,377,498	535,694	1,913,192
Buffalo (fiscal agent)	0.26%	484,578	188,447	673,025
Clark	0.59%			
Pepin	0.14%			
Calumet (fiscal agent)	.77%	1,657,988	644,773	2,302,761
Outagamie	3.00%			
Waupaca	1.00%			
Chippewa	1.08%	380,068	147,804	527,872
Columbia	1.01%	352,983	137,271	490,254
Dodge	1.63%	570,733	221,952	792,685
Douglas	0.81%	285,321	110,958	396,279
Dunn	0.76%	265,148	103,113	368,261
Eau Claire	1.74%	609,300	236,950	846,250
Fond du Lac	1.81%	667,927	259,749	927,676
Forest	0.19%	163,947	63,757	227,704
Jefferson	1.42%	499,756	194,349	694,105
Kenosha	2.78%	1,044,431	406,167	1,450,598
ADRC of Western Wisconsin		1,547,377	601,758	2,149,135
La Crosse (fiscal agent)	2.00%			
Jackson	0.36%			
Monroe	0.76%			
Vernon	0.51%			
Manitowoc	1.52%	534,036	207,680	741,716
ADRC of Central Wisconsin		1,691,993	657,997	2,349,990
Marathon (fiscal agent)	2.32%			
Langlade	0.39%			
Lincoln	0.56%			
Wood	1.39%			
Milwaukee-ARC	12.11%	2,618,222	1,018,198	3,636,420
Milwaukee-DRC	4.49%	2,074,753	806,848	2,881,601
Ozaukee	1.53%	538,148	209,280	747,428
Pierce	0.69%	283,680	110,320	394,000
ADRC of Northwest Wisconsin		473,012	183,949	656,961

Polk (fiscal agent)	0.80%			
Burnett	0.32%			
St. Croix Chippewa Indians of WI				
Portage	1.24%	494,307	192,231	686,538
Racine	3.42%	1,200,662	466,924	1,667,586
ADRC of Southwest Wisconsin North		1,031,748	401,235	1,432,983
Richland (fiscal agent)	0.33%			
Crawford	0.32%			
Juneau	0.47%			
Sauk	1.06%			
ADRC of Southwest Wisconsin South		960,003	373,334	1,333,337
Green (fiscal agent)	0.63%			
Grant	0.92%			
Iowa	0.42%			
Lafayette	0.29%			
Sheboygan	2.08%	729,013	283,505	1,012,518
St. Croix	1.30%	455,066	176,970	632,036
Trempealeau	0.50%	289,329	112,517	401,846
Walworth	1.78%	624,014	242,672	866,686
Washington	2.23%	781,147	303,779	1,084,926
Waukesha	6.72%	2,357,822	916,931	3,274,753
Waushara (fiscal agent)	0.47%	522,470	203,183	725,653
Green Lake	0.36%			
Marquette	0.29%			
Winnebago	2.95%	1,036,500	403,083	1,439,583
ADRC Subtotal	87.56%	29,889,170	11,510,225	41,399,395
Tribal Aging and Disability Resource Specialist Contracts				
Bad River		40,000	15,555	55,555
Lac Court Oreilles		40,000	15,555	55,555
Red Cliff		40,000	15,555	55,555
Tribal DBS Contracts				
GLITC		152,280	59,500	211,780
Tribal Subtotal		272,280	106,165	378,445
Grand Total		30,161,450	11,616,390	41,777,840
1/10/2011				

B. Estimated cost to expand statewide.

When the ADRC's are statewide, it is estimated that the cost will be $51,133,494 All Funds (AF). Of that, $36,816,112 will be General Purpose Revenue (GPR) and $14,317,382 will be Federal Funds (Fed Match).

The 2011 funding is $41,777,840 AF = $30,161,450 GPR + $11,616,390 Fed Match.

The Department plans an additional $ 9,355,654 AF = $6,654,662 GPR + $2,700,992 Fed Match for expansion statewide. These numbers include estimates for tribal expansion and multi-county incentives.

C. How the State will access the resources and create the revenue opportunities necessary for sustainable ADRC implementation on a statewide basis.

The 2011-13 State Budget includes current (2011) levels of funding to support established ADRCs, and includes the additional funding needed to expand ADRCs statewide by 2013.

D. Estimated projected cost savings/ offsets of having fully functional ADRCs statewide.

Aging and Disability Resource Centers impact the long-term care system in many ways, including the overall costs of long-term care.

- By advertising to and offering educational opportunities to people before they need long-term care and while they have sufficient funds to pay for care themselves;
- By providing accurate, complete, and useful information about home and community based care, services and supports;
- By teaching people how to save and use their own funds wisely;
- By teaching people how to care for themselves and loved ones, delaying the need for long-term care services;
- By providing information about and connecting them with services that delay or minimize the effects of long-term disabilities;
- By reaching out to isolated populations who might otherwise access the "system" at a time when they are most in need (and most costly);
- By assessing people for early dementia and getting them connected with the services they need;
- By offering support and other opportunities for caregivers, the ADRC can influence caregiver's satisfaction with their role as a caregiver, in turn, maintaining and extending the availability of natural supports;
- By building critical pathways between providers and communities to build resources, streamline access to services and funding sources;
- By relocating people from institutions;
- By diverting people from institutions;
- By enrolling people in home and community based programs and avoiding institutional admission.

All of these activities impact people's health and personal financial situation which in turn, reduces the costs and delays or prevents altogether the need for State and Federal funding.

The Department is in the process of refining and expanding the metrics used to measure the cost impact of ADRCs on the publicly funded long-term care system.

While data is available today (and included in the report below), the cost impact of implementing the Goals set forth in this five-year plan have the potential to impact individuals and systems significantly. Each project will be evaluated and the impact, including the cost impact, will be measured.

Current Data Regarding Cost Impact of ADRCs in Wisconsin

Even while comprehensive measures are under development, the fiscal impact is still evident in the data available to date.

In February, 2010, the State released its first annual ADRC Status Report. The report includes current information about the financial impact of ADRCs based on available data. Highlights from the report, related to the cost impact of ADRCs, include the following:

1. Benefits Counseling

Benefit Specialists help people access Social Security, SSI, SSDI, Medicare and Medicaid, FoodShare, indigent drug programs, private insurance and other benefits that people are entitled to.

The Benefit Specialist program is responsible for adding $88.4 million in additional income for Wisconsin seniors and people with disabilities. Elderly Benefit Specialists helped Wisconsin seniors access $46.5 million in benefits in 2009. Disability Benefit Specialists helped people with disabilities access $42.4 million in benefits in 2009.

In 2009, a total of 36,845 people received services from a benefit specialist.

* Source: DBS 2009 Summary Data Report and data from SAMS and Legal Action of Wisconsin, Inc.

2. Prevention

Participants in the Living Well chronic diseases self management program reported a 27% decrease in emergency department visits and a 13% decrease in hospital stays in the six months after completing the program, while participants in the Stepping On falls prevention program reported a 45% decrease in falls and a 9% decrease in emergency room visits.

Estimated savings, based on data from the Wisconsin Hospital Association, are $1,537 per avoided emergency room visit for persons over age 65 and $19,263 per avoided hospital stay.

* Source: Wisconsin Institute for Healthy Aging: Status Report on Transforming Life in Wisconsin to Make Healthy Aging a Vibrant Part of Every Community, WIHA Task Force, February 2010.

3. Information and Assistance and Options Counseling

In 2009, 32 ADRCs responded to over 308,523 requests for assistance, averaging almost 26,000 per month. During those contacts, a total of 454,029 activities were provided. (An 'activity' is a service provided to an ADRC customer.)

In approximately 90.2%* of instances, the ADRC service provided relates to maintaining individuals in their homes. About 9.8%* of the time the main issue prompting the customer to contact the ADRC was related to assisted living or nursing facilities.

Through information and assistance and options counseling, ADRCs help delay or avoid the need for nursing home care by helping people to understand the alternatives and make judicious use of their personal financial resources, thus reducing demand for publicly funded long-term care. Data in regard to the overall impact of having 308,523 conversations with people about home and community options and services is unavailable. This is one area where measures are under development.

* Source: 2010 customer satisfaction evaluation data re: customer-reported main reasons or issues for contacting the ADRC. N=2308.

4. Nursing Home Relocations

ADRCs assist people in relocating from nursing homes and assisted living facilities.

Judging from the experience of three state programs to relocate and divert people from nursing homes and facilities for the developmentally disabled, the savings can be substantial. Some 774 Wisconsin residents were relocated from nursing homes and institutions in state fiscal year 2010. The average savings from relocating to home or community based settings ranged from an average of $45.24 to $71.97 per person per day, depending on the program used to fund the relocation.

* Source: Wisconsin DHS, SFY 2010 Report on Relocations and Diversions from Institutions, December 29, 2010.

5. Access to Home and Community Based Long-Term Care Programs

Many people need publicly funded long-term care programs in order to maintain or improve their health and functioning and remain at home. ADRCs outreach to populations that might benefit from home and community based long-term care programs. ADRCs are the single entry point for accessing these programs. By accessing the programs needed to support people to stay in their homes, people are less likely to enter or are prevented from entering a nursing home.

People who are both functionally and financially eligible for long-term care programs receive enrollment counseling when there is funding available to enroll them. In 2009, 10,885 people received enrollment counseling. Using data available from Wisconsin long-term care programs, an average of 95.4% of program participants enrolled through an ADRC or county reside in home and community based settings.

SECTION IV: ADRC FIVE YEAR STATEWIDE PLAN APPROVAL

Janice Smith
Director of the State Office for Resource Center Development

7/1/11
Date

Donna McDowell
Director of the State Unit on Aging

7/1/11
Date

Director of the State Disability Agency

7/1/11
Date

Director of the State Medicaid Agency

7/1/11
Date